NOTE: All sections reference the Patient Protection and Affordable Care Act unless otherwise indicated.

**Governance and Leadership**

**Sec. 2801. MACPAC Assessment of Policies Affecting All Medicaid Beneficiaries.** Membership of the Medicaid and CHIP Payment and Access Commission (MACPAC) shall include individuals who have had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in (among other things) HIT, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

**Sec. 3011. National Strategy (to Improve Health Care Quality).** Requires the Sec. to establish a national strategy and identify national priorities to improve the delivery of health care services, patient health outcomes, and population health. The Sec. must submit the National Strategy to Congress by January 1, 2011, and update it not less than annually.

- Priorities must (among other things): address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques; enhance the use of health care data to improve quality, efficiency, transparency, and outcomes; and improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and re-admissions, and HAIs.

- The national strategy shall include a comprehensive strategic plan that shall include provisions for incorporating quality improvement and measurement in the strategic plan for HIT required by ARRA.

**Sec. 3012. Interagency Working Group on Health Care Quality.** President shall convene a working group to be known as the Interagency Working Group on Health Care Quality tasked with:

- Achieving collaboration, cooperation, and consultation among Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with national priorities identified in the National Strategy.

- Avoiding inefficient duplication of QI efforts and resources, and establishing a streamlined process for quality reporting and compliance requirements.

- Assessing alignment of quality efforts in the public sector with private sector initiatives.

The Working Group shall be composed of senior level representatives of HHS, CMS, NIH, CDC, FDA, HRSA, AHRQ, ONCHIT, SAMHSA, Admin for Children & Families, Dept of Commerce, OMB, USC, Fed Bureau of Prisons, NHTSA, FTC, SSA, DOL, USOPM, DOD, DOE, DVA, VHA etc.

Not later than December 31, 2010, and annually thereafter, the Working Group shall submit to Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group.

**Sec. 5101. National Health Care Workforce Commission.** Establish a National Health Care Workforce Commission that (among other things) that encourages innovations to address population needs, constant changes in technology, and other environmental factors. **High priority**
topics to be considered by the commission include an analysis of the nature, scopes of practice, and demands of health care workers in the enhanced information technology and management workplace.

No later than October 1 of each year beginning with 2011, the Commission shall submit a report to Congress and the Administration containing the results of reviews of current and projected workforce supply and demand and recommendations concerning related policies.

- No later than April 1 of each year beginning with 2011, the Commission shall submit a report to Congress and the Administration containing a review of, and recommendations on, at a minimum one high priority topic.

Standards

**Administrative Simplification**

**Sec. 1104. Administrative Simplification.** Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans that are governed under the Health Insurance Portability and Accountability Act (such as benefit eligibility verification, prior authorization and electronic funds transfer payments). Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary.

- In adopting standards and operating rules for financial and admin transactions (see Sec. 1173 of SSA), the Sec. shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers.
- Sec. shall adopt single set of operating rules recommended by a multi-stakeholder consensus-based qualified nonprofit entity focused on administrative simplification for each financial and admin transaction with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and in the manner in which they operate pursuant to standards issued under HIPAA. NCVHS must evaluate whether such operating rules are consisted with electronic standards adopted for HIT and recommend to the Sec. whether to adopt them or not.
- Effective dates:
  - The set of operating rules for eligibility for a health plan and health claim status transactions shall be adopted not later than July 1, 2011, in a manner ensuring that such operating rules are effective not later than January 1, 2013.
  - The set of operating rules for eligibility for electronic funds transfers and health care payment and remittance advice transactions shall be adopted not later than July 1, 2012, in a manner ensuring that such operating rules are effective not later than January 1, 2014.
  - The set of operating rules for health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization transactions shall be adopted not later than July 1, 2014, in a manner ensuring that such operating rules are effective not later than January 1, 2016.
- Standards and operating rules must be reviewed biennially as of April 1, 2014. Review committee must ensure appropriate coordination with the standards that supported the certified EHR technology approved by ONCHIT.
- Sec. shall promulgate an interim final rule to establish a transaction standard and a single set of associated operating rules for health claims attachments that is consistent with the X12 Version 5010 transaction standards.
Sec. shall promulgate final rule (or interim final rule) for establishing a unique health plan identifier (per Sec. 1173(b) of SSA) based on input from NCVHS effective no later than October 1, 2012.

(Amending Sec. 1104) Sec. 10109. Development of standards for financial and administrative transactions. Requires the Secretary to consult stakeholders and the National Committee on Vital and Health Statistics and the Health Information Technology Standards and Policy Committees to identify opportunities to create uniform standards for financial and administrative health care transactions, not already named under HIPAA, that would improve the operation of the health system and reduce costs. The Secretary must solicit this input not later than January 1, 2012, and not less than every 3 years thereafter.

Health Disparities

Sec. 4302. Understanding Health Disparities: Data Collection and Analysis. Requires the Secretary to ensure, by not later than 2 years after date of enactment, any ongoing or new federally conducted or supported health care or public health program, activity, or survey collects and reports data by race, ethnicity, primary language, disability status, and any other indicator of disparity for applicants, recipients, and participants – so long as funds are directly appropriated for such purpose in an appropriations Act.

- This data should be collected at the smallest geographic level practicable if such data can be aggregated. Sufficient data should be collected to generate statistically reliable estimates by subgroups.
- OMB standards, at a minimum, should be used for race and ethnicity measures. The Secretary or a designee should develop standards for the measurement of sex, primary language, and disability status, and standards for the collection of self-reported data.
- The Secretary, acting through the National Coordinator for HIT, shall develop national standards for the management of data collected, and develop interoperability and security systems for data management.
- The Sec. shall establish procedures for sharing data collected, measures relating to such data, and analyses of such data, with other relevant Federal and State agencies and centers including those within HHS.
- The Sec. shall ensure that all data collected is protected under privacy protections that are at least as broad as those that the Sec. applies to other health data under HIPAA regulations and data is protected from all inappropriate internal use by an entity that collects, stores, or receives data, including use of such data in determination of eligibility or continued eligibility in health plans.
- The Sec. shall ensure that all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected.
- Medicare data collection and reporting requirements are extended to Medicaid and CHIP.

Other

Sec. 1561. HIT Enrollment Standards and Protocols. Not later than 180 days after enactment, the Sec., in consultation with the HIT Policy and Standards Committees, shall develop interoperable and secure standards and protocols that facilitate enrollment in Federal and State health and human services programs through methods that include providing individuals and authorized 3rd parties notification of eligibility and verification of eligibility.

- Sec. shall notify States of standards and protocols approved by the HIT Policy and Standards Committees
• **Sec. shall award grants to develop new, and adapt existing, technology standards to implement HIT enrollment standards and protocols.**

• Sec. may require that States or other entities incorporate such standards and protocols as a condition of receiving Federal funds for the HIT investments.

• **Sec. shall determine what entities are qualified to receive enrollment HIT, taking into consideration recommendations of the Policy and Standards Committees.**

**Sec. 3015. Data Collection; Public Reporting – Collection and Analysis of Data for Quality and Resource Use Measures.** The Sec. shall provide standards for the protection of the security and privacy of patient data related to the collection and aggregation of consistent data on quality and resources use measures. (For more information, see “Measurement & Reporting Section.”)

**Sec. 3506. Program to Facilitate Shared Decision Making – Establishment of Independent Standards for Patient Decision Aids for Preference Sensitive Care.** For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care and a certification process for patient decision aids for use in the Federal health programs, and by other interested parties, the Sec. shall enter into a contract with NQF for 18 months (starting as soon as practicable after the date of enactment).

- NQF shall synthesize evidence and convene a broad range of experts and stakeholders to develop and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.
- NQF shall review patient decision aids and develop a certification process.

**Sec. 6703. Elder Justice – Adoption of Standards for Transactions Involving Clinical Data by LTCFs.** Sec. shall adopt electronic standards for the exchange of clinical data by LTCFs, including, where available, standards for messaging and nomenclature. No later than 10 years after enactment of the Elder Justice Act of 2009, the Sec. shall have procedures in place to accept the optional electronic submission of clinical data by LTCFs pursuant to standards. Nothing in this section requires LTCF to submit clinical data electronically to the Secretary.

**Use of HIT in Delivery of Care**

**Incentives/Payment**

**Sec. 1001. Amendments to the Public Health Service Act – Ensuring the Quality of Care.** Not later than 2 years after enactment, the Sec. shall develop reporting requirements for private plans with respect to plan or coverage benefits and health care provider reimbursement structures that implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and HIT.

**Sec. 1311. Affordable Choices of Health Benefits – Rewarding Quality through Market-Based Incentives.** The Sec., in consultation with experts in health care quality and stakeholders, shall develop guidelines for a payment structure that provides reimbursement or other incentives for the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and HIT under the plan or coverage. Guidelines shall require periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy.

**Sec. 1322. Federal Program to Assist Establishment and Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP program).** Qualified nonprofit health
insurance issuers participating in the CO-OP program may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase admin and other cost efficiencies, including claims admin, admin services, HIT, and actuarial services. Not later than July 1, 2013, the Sec. shall award and begin distribution of the loans and grants under the CO-OP program.

**Sec. 2703.** State Option to Provide Health Homes for Enrollees with Chronic Conditions (Medicaid).

Beginning January 1, 2011, States have the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. A state exercising this option must include in its State plan amendment:

- Methodology for tracking avoidable hospital re-admissions and calculating savings that result from improved chronic care coordination and management.
- A proposal for use of HIT in providing health home services and improving service delivery and coordination across the care continuum (including use of wireless patient technology to improve coordination and management of care and patient adherence).
- As a condition for receiving payment for home health services, providers must report to the State on all applicable measures for determining quality of such services. When appropriate and feasible, a designated provider shall use HIT in providing the State with such information.
- Health home services include the use of HIT to link services, as feasible and appropriate.

**Sec. 3022.** Medicare Shared Savings Program. (ACOs). No later than January 1, 2012, the Sec. shall establish a shared savings program that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Participating ACOs shall define processes to promote EBM and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies. The Sec. may incorporate reporting requirements and incentive payments related to PQRI, including such requirements and such payments related to e-Rx, EHRs and other similar initiatives, and may use alternative criteria than would otherwise apply for determining whether to make such payments. These incentive payments shall not be taken into consideration when calculating any payments otherwise made under ACO program.

**Sec. 3201.** Medicare Advantage Payment. For years beginning with 2014, MA plans shall receive monthly care coordination and management performance bonuses (details pg 884-885) if they conduct an HIT program, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care. (Section struck by Sec. 1102 (a) of the reconciliation package)

**Sec. 3502.** Establishing Community Health Teams to Support the Patient-Centered Medical Home. Creates a program to establish and fund the development of community health teams to support the development of medical homes by increasing access to comprehensive, community based, coordinated care.

- Community health teams shall support PCMHs, a mode of care that includes safe and high-quality care through evidence-informed medicine, appropriate use of HIT, and continuous QIs.
- Community health teams shall provide support necessary for local PCPs to (among other things) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and
identification of areas for improvement, and establish a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of infolines, HIT, or other means.

- Community health teams shall demonstrate a capacity to implement and maintain HIT that meets the requirements of certified EHR technology to facilitate coordination among members of the applicable care team and affiliated PCPs.

**Sec. 4103. Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan.** Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services that include health risk assessments, for which the Sec. shall establish publicly available guidelines within 1 year of enactment of this subsection.

- Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a HRA may be furnished through an interactive telephonic or web-based program that meets standards to be established by the Secretary within 1 year of enactment of this subsection. Within 18 months of enactment, the Sec. shall develop and make available to the public a HRA model.

Sec. shall encourage the use of, integration with, and coordination of HIT (including use of technology that is compatible with EHRs and PHRs) and may experiment with the use of personalized technology to aid in the development of self-management skills and management of adherence to provider recommendations in order to improve the health status of beneficiaries.

**Sec. 10333. Community-Based Collaborative Care Networks.** The Secretary may award grants to support community-based collaborative care networks. Grant funds may be used to (among other things) expand capacity, including through telehealth, after-hours services or urgent care.

**Sec. 10410. Centers of Excellence for Depression.** Awards grants to establish national centers of excellence for depression, which shall engage in activities related to the treatment of depressive disorders. Each Center shall collaborate with other Centers in the network to use EHRs and telehealth technology to better coordinate and manage, and improve access to, care, as determined by the coordinating center.

**Demonstrations & Pilots**

**Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.** Establishes within the Centers for Medicare & Medicaid Services (CMS) a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare. Successful models can be expanded nationally. The Secretary is required to ensure that the CMI will begin carrying out its duties by no later than January 1, 2011.

- Models to be tested include supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a HIT-enabled provider network that includes care coordinators, a chronic disease registry, home tele-health technology, and telehealth services in treating behavioral health issues and stroke and improving the capacity of non-medical providers and non-specialized medical providers to provide health services for patients with chronic complex conditions.
• In selecting models for testing the CMI may also consider (among other things) whether the model utilizes technology, such as EHRs and patient-based remote monitoring systems, to coordinate care over time and across settings.

Sec. 3023. National Pilot Program on Payment Bundling. Sec. shall establish a 5 year pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services. Sec. shall develop quality measures for use in the pilot program for episodes of care and for post-acute care. To the extent practicable, the Sec. shall specify that data on measures to be submitted through the use of a qualified EHR in a manner specified by the Sec. At any point after January 1, 2016, the Sec. may expand the duration and scope of the pilot program if the expansion is expected to reduce spending without reducing the quality of care or improve the quality of care and reduce spending.

Sec. 3024. Independence At Home Demonstration Program. Sec. shall conduct a demo to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes. Participating medical practices must use electronic health information systems, remote monitoring, and mobile diagnostic technology. In approving practices, Sec. shall give preference to those that use EMRs, HIT and individualized plans of care (among other things). The demonstration program shall begin no later than January 1, 2012.

Sec. 5604. Co-Locating Primary and Specialty Care in Community-Based Mental Health Settings. Sec. shall award grants and cooperative agreements to establish demonstration projects for provision of coordinated and integrated services to special populations through the co-location of primary care and specialty care services in community-based mental and behavioral health settings. Funds may be used for IT required to accommodate the clinical needs of primary and specialty care professionals. Funds authorized to be appropriated for FY2010 through 2014.

Sec. 6114. National Demonstration Projects on Cultural Change and Use of IT in Nursing Homes. Establishes a demonstration project for the development of best practices in skilled nursing facilities and nursing facilities for the use of IT to improve resident care. Demonstration project shall be implemented not later than 1 year after the date of enactment of this Act.

Measurement & Reporting

PQRI

Sec. 3002. Improvements to the Physician Quality Reporting System – Integration of Physician Quality Reporting and EHR Reporting. Not later than January 1, 2012, the Sec. shall develop a plan to integrate reporting on quality measures under PQRI with reporting requirements relating to the MU of EHRs. Such integration shall consist of the selection of measures, the reporting of which would both demonstrate MU of an EHR for purposes of subsection (o) and quality of care furnished to an individual, and other activities specified by the Sec.
Measure Development

Sec. 3013 Quality Measure Development. Authorizes $75 million over 5 years for the development of quality measures at AHRQ and the Centers for Medicare and Medicaid Services (CMS). Gaps in quality measures will be identified not less often than triennially. Quality measures developed under this section will be consistent with the national strategy.

- In awarding grants/contracts for developing, improving, updating, or expanding quality measures, Sec. shall give priority to measures that allow the assessment of meaningful use (among other things).
- Grant/contract recipients shall use awards to develop quality measures that (among other things), to the extent practicable, data on such quality measures is able to be collected using HIT and each quality measure is publicly available on an Internet website.

Public Reporting

Sec. 3015. Data Collection; Public Reporting – Collection and Analysis of Data for Quality and Resource Use Measures. The Sec. shall collect and aggregate consistent data on quality and resource use measures from information systems used to support health care delivery, and may award grants or contracts for this purpose.

- Grants or contracts may only be awarded to entities that enable summary data that can be integrated and compared across multiple sources.

(Amending Sec. 3015). Sec. 10305. Data Collection; Public Reporting. The Sec. shall align such collection and aggregation efforts with the requirements and assistance regarding the expansion of HIT systems, the interoperability of such technology systems, and related standards.

Sec. 3025. Hospital Readmission Reduction Program. Beginning on or after October 1, 2012, the Sec. shall adjust payments for hospitals paid under the inpatient prospective payment system based on the dollar value of each hospital’s percentage of potentially preventable Medicare readmissions for the three conditions with risk adjusted readmission measures that are currently endorsed by NQF. As of FY2015, Sec. can expand the policy to additional conditions.

- Hospital readmission rates will be posted publicly on the Hospital Compare website.

Sec. 10331. Public Reporting on Performance Information. Requires the Sec. to develop a “Physician Compare” website where Medicare beneficiaries can compare scientifically-sound measures of physician quality and patient experience measures, provided that such information provides an accurate portrayal of physician performance.

- Website with information on Medicare- and PQRI-participating physicians must be developed no later than January 1, 2011.
- Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, Sec. must implement a plan for making publicly available info on physician performance (including comparable information on quality and patient experience measures) through the Physician Compare website.

Sec. 10332. Availability of Medicare Data for Performance Measurement. Authorizes Sec. to release and allow the use of standardized extracts of Medicare claims data to measure the performance of providers and suppliers in ways that protect patient privacy and in accordance with other requirements.
Implementation Support

Sec. 3501. Health Care Delivery System Research – QI Technical Assistance. The Director of the Center for QI and Patient Safety shall award technical assistance and implementation grants or contracts to provide support to providers so that they understand, adapt, and implement the delivery models and practices identified by the Center’s research. Grantees shall coordinate with HIT RECs and the primary care extension program regarding the dissemination of QI, system delivery reform and best practices information.

Sec. 3506. Program to Facilitate Shared Decision Making – Program to Develop, and Produce Patient Decision Aids to Assist Health Care Providers and Patients. The Director shall establish a program to award grants or contracts to develop, update, produce, and test patient decision aids, and educate providers on their use. The Director shall ensure that patient decision aids produced with such grants or contracts are available to the public.

Sec. 3506. Program to Facilitate Shared Decision Making – Grants to Support Shared Decision Making Implementation. The Sec. shall establish a program to provide for the phased-in development, implementation, and evaluation of shared decision making using patient decision aids to meet the objective of improving the understanding of patients of their medical treatment options. Funds authorized to be appropriate starting in FY2010.

- The Sec. shall provide grants for the establishment and support of Shared Decision Making Resource Centers to provide technical assistance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decision making.
- The Sec. shall provide grants to health care providers for the development and implementation of shared decision making techniques and to assess the use of such techniques.

Sec. 6703. Elder Justice – Certified EHR Technology Grant Program. The Sec. is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing and implementing certified EHR technology designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors. Funds, authorized to be appropriated for FY 2011-2014, may be used for any of the following:

- Purchasing, leasing, and installing computer software and hardware, including handheld technologies.
- Making improvements to existing hardware software.
- Making upgrades and other improvements to existing computers software and hardware to enable eRx-ing.
- Providing education and training to eligible LTC facility staff on the use of such technology to implement the electronic transmission of Rx and patient information.
- The Sec. shall develop accountability measures to ensure that the activities conducted using these funds help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

Secondary Uses

Sec. 3501. Health Care Delivery System Research. The Center QI and Patient Safety of AHRQ shall support research on health care delivery system improvement and the development of tools to facilitate adoption of best practices that improve the quality, safety, and efficiency of health
care delivery services. Research shall expand demonstration projects for improving the quality of children’s health care and the use of HIT, such as through Pediatric QI Collaboratives and Learning Networks. Funding for these activities is authorized to be appropriated for FY2010-2014.

- The Center for shall carry out its functions using research from a variety of disciplines, including health informatics.
- Sec. shall ensure that research findings and results generated by the Center are shared with ONCHIT and used to inform the activities of the HIT extension program, as well as any relevant standards, certification criteria, or implementation specifications.
- In prioritizing the Center’s research and dissemination activities of the Center, the Director shall take into account (among other things) the evolution of MU.

Sec. 4301. Research on optimizing the delivery of public health services. The Secretary, acting through the Director of CDC, shall provide funding for research in the area of public health services and systems. This research shall include examining best practices relating to prevention, analyzing the translation of interventions from academic institutions to clinics and communities, and identifying effective strategies for delivering public health services in real world settings. CDC shall annually report research findings to Congress.

Sec. 6301. Patient-Centered Outcomes Research. – Dissemination and Building Capacity for Research. Establishes a private, nonprofit entity (the Patient-Centered Outcomes Research Institute) governed by a public-private sector board appointed by the Comptroller General to identify priorities for and provide for the conduct of comparative outcomes research.

- The Office of Communication and Knowledge Transfer at AHRQ shall disseminate the Institute’s research findings and government funded research relevant to CER to vendors of HIT focused on clinical decision support (among others).
- The Office shall assist users of HIT focused on clinical decision support to promote the timely incorporation of research findings into clinical practices and to promote the ease of such incorporation.
- The Office shall establish a process to receive feedback from physicians, health care providers, patients, vendors of HIT focused on clinical decision support, appropriate professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided.
- Sec. shall provide for the coordination of relevant Federal health programs to build data capacity for CER, including the development and use of clinical registries and health outcomes research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including EHRs.

Workforce & Training

Sec. 5101. National Health Care Workforce Commission. See “Governance and Leadership” section.

Sec. 5301. Training in Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship. – Primary Care Training and Enhancement. Sec. shall make grants to or enter into contracts with accredited schools of medicine or osteopathic medicine to build capacity in primary care. Sec. shall give priority to applicants that (among other things) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive care, HIT or other recommended competencies. Funds authorized to be appropriated for FY2010-2014.
Sec. 5405. Primary Care Extension Program. Primary Care Extension Program shall provide support and assistance to primary care providers to educate them about preventive medicine, health promotion, chronic disease management, mental and behavioral health services, and evidence-based and evidence-informed techniques and therapies. In carrying out related activities, the Sec. shall consult with the heads of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as ONCHIT. Funds authorized to be appropriated for FY 2011-2014.

Other Telehealth

Sec. 6407. Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment under Medicare. Includes telehealth encounters under definition of face-to-face encounters for certifications made after January 1, 2010.

Sec. 10328. Improvement in Part D medication therapy management (MTM) programs. (Manager’s Amendment) Requires Part D prescription drug plans to include a comprehensive review of medications (either in person or through telehealth technology) and a written summary of the review as part of their medication therapy management programs for plan years beginning on or after 2 years after the date of enactment of the Act.

Other Infrastructure

Sec. 10330. Modernizing computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery. (Manager’s Amendment) Requires the Secretary of HHS to develop a plan within 9 months of enactment (and a detailed budget for the resources needed to implement such plan) to modernize the computer and data systems of the Centers for Medicare & Medicaid Services to support improvements in care delivery. In developing the plan, the Sec. shall consider how such modernized computer system could:

- Make data available in a reliable and timely manner to providers of services and suppliers to support their efforts to better manage and coordinate care furnished to CMS program beneficiaries.
- Support consistent evaluations of payment and delivery system reforms under CMS programs.

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